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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ROSEMARY MARTINEZ ALVAREZ** **2658 E. Kelso Avenue** **Fresno, CA 93720** **Registered Nurse License No. 554529** **Public Health Nurse Certificate No. 60579** Respondent.	Case No. 2012-730 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about April 27, 1999, the Board issued Registered Nurse License Number 554529 to Rosemary Martinez Alvarez ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2012, unless renewed.

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Public Health Nurse Certificate

3. On or about May 18, 1999, the Board issued Public Health Nurse Certificate Number 60579 to Rosemary Martinez Alvarez ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2012, unless renewed.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states, in pertinent part:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> (f) Conviction of a felony or any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of conviction shall be conclusive evidence thereof."

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse....

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

10. **DRUG**

"Morphine/Morphine Sulfate" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022 in that it requires a prescription under federal and state law.

BACKGROUND

11. On or about July 4, 2009, Patient V.M. was transported by ambulance to her home, after being released from Saint Agnes Medical Center, Fresno, California, with a diagnosis of cancer and a life expectancy of approximately 6 months. Patient V.M. was placed on hospice care and given a CADD pump[1] for pain management that was associated with a cracked rib caused by her cancer. Morphine was ordered by Dina Ibrahim, M. D. and was for a concentration of 1 mg/ml and the dose of 2 mg per hour with a bolus[2] of 2 mg every 20 minutes for breakthrough pain. On July 5, 2009, the dose of Morphine was titrated upward to achieve better pain relief. The new dose was 2 mg/hour with a bolus of 4 mg every 20 minutes for breakthrough pain.

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[1] CADD pump is a computerized ambulatory drug delivery system. The pump employs automatic, programmable pumping mechanisms to deliver continuous anesthesia, drugs, and blood infusions to the patient.

[2] Bolus is a large volume of fluid or dose of a drug given intravenously and rapidly at one time.

12. On July 6, 2009, Respondent was assigned as the afterhours on call nurse. At approximately 10:12 p.m., Respondent received a call from the patient's family stating that the patient had only 8 ml of Morphine left in the cassette and they did not know how to change the cassette. Respondent arrived at the patient's home at approximately 11:06 p.m. and replaced the cassette with a new cassette and instructed family members on how to change the Morphine cassette in the future. Respondent failed to notice that the dose on the new Morphine cassette was 20 mg and not 2 mg. Respondent did not reprogram the CADD for the stronger medication, which resulted in the patient being overdosed with Morphine. Respondent failed to chart that she changed the Morphine cassette. The patient subsequently passed away on July 10, 2009. The cause of death was classified as Morphine intoxication.

FIRST CAUSE FOR DISCIPLINE

(Criminal Conviction)

13. Respondent is subject to discipline pursuant to Code section 2761, subdivision (f), in that on January 6, 2012, in the Superior Court, Central Division, County of Fresno, California, in the matter entitled *People vs. Rosemary Martinez Alvarez*, (2011), Case No. F11905949, Respondent was convicted by the court following her plea of nolo contendere to a violation of Penal Code section 368, subdivision (b)(1) (elder or dependent abuse, resulting in death), a felony. The circumstances of the crime are that on or about July 6, 2009, Respondent changed Patient V.M.'s CADD cassette containing Morphine without verifying the strength of the medication and reprogramming the CADD for the stronger medication, resulting in the patient's death due to Morphine intoxication. On May 3, 2012, the court sentenced Respondent to serve 365 days in the county jail and two years formal probation. Respondent was further ordered not to have contact with or be involved in the care of elderly or dependent adults and not to administer, prepare, or assist in the administration of drugs, narcotics, or medicine on any patient for the period of probation.

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the ground of unprofessional conduct, in that while on duty as a registered nurse, employed by Hinds Hospice and caring for Patient V.M. (a 75 year-old female patient with terminal cancer), Respondent committed acts constituting gross negligence, as defined in California Code of Regulations, title 16, section 1442, as follows:

a. Respondent failed to follow the "Rights" of medication administration and verify that the cassette contained the right concentration of Morphine and that the patient was receiving the right dose pursuant to the physician order.

b. Respondent failed to recognize that the concentration of Morphine was stronger, which would have required reprogramming the CADD pump to accommodate the stronger medication.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

15. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the ground of unprofessional conduct, in that , while on duty as a registered nurse, employed by Hinds Hospice and caring for Patient V.M., Respondent committed acts constituting incompetence, as defined in California Code of Regulations, title 16, section 1443, as follows:

a. Respondent failed to follow the "Rights" of medication administration and verify that the cassette contained the right concentration of Morphine and that the patient was receiving the right dose pursuant to the physician order.

b. Respondent failed to recognize that the concentration of Morphine was stronger, which would have required reprogramming the CADD pump to accommodate the stronger medication.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as more particularly set forth in paragraphs 13 through 15, above.

FACTORS IN AGGRAVATION

17. Respondent, while on duty as a registered nurse for Hinds Hospice and making home visits, changed doses of medications without first obtaining a physician order for the following patients:

Patient #3

a. On or about June 11, 2008, the physician's order for this patient was for 20 mg of Dilaudid by intravenous every one (1) hour. On June 12, 2008, Respondent incorrectly documented in the patient's progress notes that she had instructed the patient's wife about how to give the patient a bolus of Morphine Sulfate by increasing the hourly rate to 40 mg. Respondent incorrectly documented Morphine Sulfate; when the patient was actually receiving Dilaudid. Further, Respondent changed the rate of the Dilaudid that the patient was receiving prior to obtaining a physician order to do so.

Patient #4

b. On June 11, 2008, the physician order for this patient was for 5 mg of Morphine liquid by oral/sublingual every four (4) hours for pain. This order was discontinued on June 12, 2008. Further, on June 12, 2008, it was noted in the patient's record that this patient was given 37.5 mg of liquid Morphine. 2.5 mg of liquid Morphine were administered before Respondent's nursing visit. Subsequently, Respondent administered 5 mg of morphine at 0100 hours; 10 mg of morphine at 0130 hours; and 20 mg of morphine at 0215 hours. In total, Respondent administered 35 mg of liquid Morphine to this patient over a period of one hour and 15 minutes, which exceeded the physician order for 5 mg every four (4) hours.

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c. On June 13, 2008, at 2555 hours, Respondent spoke to the nurse for Dr. Chooljian and requested a one-time order for Morphine Sulfate titration until pain relief, up to 40 mg; however, the patient's record does not indicate the medication was titrated on that date.

Patient #5

d. On or about June 10, 2008, the physician order for this patient was for Roxanol (Morphine Sulfate) 60 mg by oral/sublingual every 1-2 hours as needed for breakthrough pain. On or about June 12, 2008, Respondent spoke to the patient's son and instructed him to administer a double dose of Roxanol one time, which was 120 mg, prior to obtaining a physician order to do so.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 54529, issued to Rosemary Martinez Alvarez;

2. Revoking or suspending Public Health Nurse Certificate Number 60579, issued to Rosemary Martinez Alvarez;

3. Ordering Rosemary Martinez Alvarez to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: June 6, 2012

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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